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A CASE STUDY OF COMMUNITY-LEVEL INTERVENTION FOR NON-COMMUNICABLE DISEASES IN KHAYELITSHA, CAPE TOWN

Empowerment of Women and Girls

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September 2013

The IDS programme on Strengthening Evidence-based Policy works across six key themes. Each theme works with partner institutions to co-construct policy-relevant knowledge and engage in policy-influencing processes. This material has been developed under the Empowerment of Women and Girls theme.

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This document constitutes a framing brief and summary of the non-communicable disease (NCD) case study which has been written as a contribution to the Empowerment of Women and Girls theme of the Accountable Grant at the Institute of Development Studies (IDS). In particular it relates to the sub-theme that focuses on the health of women and girls in rapidly urbanising settings in Kenya and South Africa.

In 2001 the School of Public Health at the University of the Western Cape (UWC) commenced the implementation of an intervention to address the burden of non-communicable diseases (NCDs) in a low-resource area of Khayelitsha, a poor urban township of Cape Town (see accompanying case study). The rising burden of NCDs has been historically neglected on the policy front in countries such as South Africa, struggling with a 'double burden' of infectious and non-communicable disease. Low and middle income country (LMIC) governments in Africa are now developing policy to address the NCD burden but there are as yet few interventions that have been implemented in such settings. This case study describes one of the few NCD interventions implemented to date in such a setting, and this initiative by UWC was the only intervention with published results that could be identified in a peri-urban setting in sub-Saharan Africa in a thematic literature review carried out by IDS. In addition, in its design this NCD intervention aimed to be sensitive to local socio-economic and cultural contexts and to intersect with an existing NGO-run community health worker (CHW) project. As the South African government is currently developing policy to expand the role of community health workers to address the 'quadruple burden' of disease, this dimension of the initiative was an additional reason to include the intervention in the case studies for this theme.

NCDs are affecting both men and women in settings like Khayelitsha. However, there are particular factors that need to be considered with respect to the way in which this burden of disease impacts on the health of women and girls in such contexts. In Khayelitsha, women are centrally involved in purchasing and preparing food, and it is also not uncommon for women to work in the informal sector selling prepared foodstuffs as 'fast food'. Women are also affected by the pervasive insecurity of this area, which has a limited number of safe spaces for doing physical activity. A high proportion of Community Health Workers (CHWs) in such a setting are women. Therefore, it is opportune to consider the extent to which an intervention, such as the one being described and reflected upon in the accompanying case study, is able to address the NCD burden affecting women in rapidly urbanising contexts. How might an intervention of this nature speak to current policy plans of the South African government to address the burden of NCDs and to expand the use of CHWs? Can an intervention like the one described in the accompanying case study influence 'good practice' and speak to interventions being designed for the broader population?

The problem of non-communicable disease and policy responses

Non-communicable diseases (NCDs) have become a major cause of mortality globally, but especially in low and middle-income countries (LMIC), where nearly 80 per cent of all NCD related deaths occur (World Health Organization (WHO), 2011). South Africa, a middle-income country, has begun to grapple with the effect of a high burden of disease imposed by NCDs along with other diseases and conditions (Bradshaw *et al*., 2002). In the Western Cape Province, where the intervention in question was implemented, NCDs were the leading cause of mortality in adults aged 40 years and older in a pooled estimate of causes of death between 2003 and 2006 (Groenewald *et al*., 2008).

The mortality pattern reflects the differential impact that NCDs have on sections of a 'community', with particularly higher rates in the poorer areas (*ibid*. 2008). Studies have shown that women, especially in developing countries, are the worst affected by this pandemic compared to male counterparts. Antiretroviral treatment has also been associated

with increased risk of hyperlipidaemia (Segarra-Newnham 2002), diabetes and hypertension (Diouf *et al*. 2012). This, in the context of the extremely high prevalence of HIV amongst women in South Africa and the large numbers enrolled in ART programmes, raises the importance of integrating the management of chronic conditions such as HIV and AIDS with NCDs, as well as the inclusion of NCDs in women's health programmes.

NCDs are associated with modifiable personal, social and environmental factors, which in turn, are related to a complexity of several factors including economic and political (Puoane *et al*. 2013). Lifestyle factors such as smoking, alcohol abuse and physical inactivity, along with obesity, which is largely triggered by unhealthy food consumption, are known to contribute to the NCD epidemic. Effective NCD reduction will have to acknowledge the multifaceted nature of the drivers of the epidemic and incorporate a multi-layered approach (WHO 2012). There has been a growing interest in tackling the burden of NCDs in the state health system in South Africa. The South African government convened a summit on the 'Prevention and Control of Non-Communicable Diseases' in September 2011, which produced a declaration that endorsed action aimed at various levels of risk factors, i.e. behavioural, environmental and structural, and further acknowledged the need for intersectoral collaboration.

A Strategic Plan for Non-Communicable Diseases 2012–2016, which provides a framework for reducing the burden of NCDs has been made available. The plan proposes a comprehensive approach to combat NCDs and focuses on three strategies: (1) prevention of NCDs and promotion of health and wellness at population, community and individual levels; (2) improving the control of NCDs through health systems strengthening and reform; and (3) monitoring of NCDs and their main risk factors and conducting innovative research. The South African government has adopted the Primary Health Care (PHC) re-engineering strategy as a means of strengthening the effectiveness of the current health system, weakened by poor infrastructure and human resource limitations. This approach has the potential to address NCDs comprehensively as its focus will be on health promotion, disease prevention and referral for curative care to improve health outcomes (DOH 2011). This approach will also assist in building the capacity of CHWs in the management of chronic conditions and provide support to CHWs through a professional nurse, health promoter and environmental officer who form part of the PHC outreach team.

The intervention

A community-based intervention programme to increase community awareness about primary prevention of NCDs was implemented in two sub-sections of Khayelitsha from 2001–2005. Khayelitsha is a large, low income housing area in the Cape Town metropole. The project was initiated in response to community requests after an increased number of people were found suffering from hypertension and diabetes. This project aimed to develop an NCD model with the assistance of CHWs, informed by the WHO strategy for prevention and control of NCDs (WHO, 2004). The intervention involved working with community health workers and engaging them as change agents to reach out in this community to address NCDs. Community members, mostly females, were screened for individual risk factors and the CHWs were trained to promote healthy lifestyles. Between 2001 and 2005 the intervention was implemented in stages, which included collecting baseline data for analysis by the research team and subsequent evaluation of the measures taken. For a full description of the intervention, see the accompanying case study. In order to assess the current operation of the programme in 2013 and to determine in what way this resembles 'good practice', a selection of key stakeholders were identified and interviewed for the case study. The stakeholders were selected to incorporate a range of positions in order to elicit diverse perspectives on the original intervention and the current NCD activities of the CHWs. The information was assessed in the light of the evolution of the intervention in the

subsequent years and recent policy developments in the Department of Health in South Africa.

This intervention demonstrated the importance of involving CHWs in the initial process of developing a targeted community intervention. An active participatory approach was applied in a stepwise process, and data collection identified cultural and environmental beliefs, as well as attitudes of the CHWs and the community members that influenced their lifestyles. Interventions that utilise local people who know the language and culture of the population they work with are likely to be more sustainable, provided that support and resources are made available.

The expectation of training CHWs on primary prevention of NCDs was to recruit people around their work areas to develop a health club where people could regularly meet and share information and concerns about health including NCDs, such as diabetes and hypertension. This assisted in sustaining the intervention. In addition, creating health clubs in areas where people live has made the intervention accessible to community members. However, accessibility is limited only to non-employed community members if the clubs are run during working hours, thereby excluding a large number of people in the community. Threats to sustainability include high turnover of CHWs, who often leave the programme for better opportunities. The intervention made an effort to think through what would be cost-effective and sustainable technology to use in such a CHW intervention. The development of a Training Manual, made available to the Department of Health, has contributed to discussions about the training of CHWs.

One of the shortcomings of this intervention as it was implemented up ntil 2005 was the focus on individual behaviours related to risk factors for NCDs rather than attempting to also address broader social determinants and environmental factors (such as the nature of the food environment and the absence of safe recreational spaces). Although social, cultural, structural and environmental determinants were identified in the research aspect of the study, addressing them needed active involvement of other sectors. This intervention initially focused on primary prevention, although it has evolved to include secondary prevention. The health promotion aspect of the intervention has been limited to reducing risk factors for NCDs through education, nutrition and physical activity, neglecting strategies to modify environmental influences. The lack of intersectoral collaboration therefore limited the impact of this intervention.

Conclusion

The focus of current government policy is on prevention and promotion. The use of CHWs to implement this intervention is in line with the new South African government policy initiative, namely PHC re-engineering. This emphasises the prevention and management of chronic diseases at community level. However, the PHC re-engineering policy puts emphasis on household-level interventions. People who therefore may not be involved in health clubs will also benefit.

Implementation of the WHO global strategy for prevention and control of NCDs is challenging in poor communities, as was the case in this intervention. Education does not guarantee behaviour modification of community members and CHWs. Unless the environment is conducive and encourages healthy living, NCDs will continue to be a burden among the poor population of South Africa. This intervention has assisted in putting the problem of NCDs in poor communities on the agenda of government and other stakeholders. This should lead to policies which support healthy lifestyles by rendering healthy foods cheaper and regulating unhealthy foods by such actions as imposition of taxes. Similarly, actions are required to promote physical activity, including improving community security by monitoring crime and creating more accessible open spaces.

The use of CHWs in the planning and implementation of such an intervention enhances accessibility, sustainability and cultural sensitivity. However, this requires the support of, and ongoing communication with, CHWs on the part of health practitioners and managers at higher levels. Such contact might also enable them to have a voice in policy interventions. Ultimately, in order to maintain the benefits of such programmes there is a need to invest in ongoing training and robust supervision. This requires the provision of resources and lobbying of political leaders for political support and policy development.